

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

9057

2540

Registrar's No.

Registration District No. 781

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Christian Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day (Specify whether)

In this community
years, months or days

3. (a) PRINT FULL NAME

Baby Schewe

3. (b) If veteran,
name war

3. (c) Social Security
No.

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced single
6. (b) Name of husband or wife 6. (c) Age of husband or wife if

7. Birth date of deceased march 15 1940
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 0 1 hr. min.

9. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation none

11. Industry or business

12. Name Charles Schewe
13. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Maria Stecher
15. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Charles Schewe

(b) Address 4914 Leahy

17. (a) burial (b) Date thereof march 18 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Bethlehem

18. (a) Signature of funeral director Benderman funeral

(b) Address 1536 St. Louis

19. (a) MAR 18 1940 (Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4914 Leahy Ave
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month march day 16
year 1940 hour 3 minute 20 P. M.

21. I hereby certify that I attended the deceased from mar. 15
1940, to mar. 16 1940;

that I last saw him alive on mar. 16 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death cerebral hemorrhage Duration

Due to pu. cephalic endothelial
mother?

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN

Underline
the cause to
which death
should be
charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature C. P. Ryan (M. D. or other)

Address 607 N. Grand St. Date signed 3.17.40

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.,
working under my personal supervision.

Signed.....

Licensed Embalmer No. 3 3737

P. O. Address 1936 St. Louis Ave

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.